OSR 5-342 (Rev 8-18-2008)

DENTAL SERVICES CLAIM FORM

Plan Administrators:
Savannah River Nuclear Solutions, LLC and
Washington Savannah River Company

DENTIST'S PRE-TREATMENT ESTIMATE
DENTIST'S STATEMENT OF ACTUAL SERVICES

BlueCross BlueShield of South Carolina

An Independent Licensee of the
Blue Cross and Blue Shield Association

PART I–TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME First Initial Last	2. Relationship to Employee Self / Spouse / Child / Other	3. Sex M / F	4. Patient Birthdate Mo. / Day / Year
5. Employee Name First Middle Last	6. Employee Social Security Number		

7. Do you or your covered dependents have any other dental insurance? ☐ No ☐ Yes
If yes, please answer the following questions:
Policyholder's Name:
SSN or ID No.:
Name and Address of Policyholder's Employer:

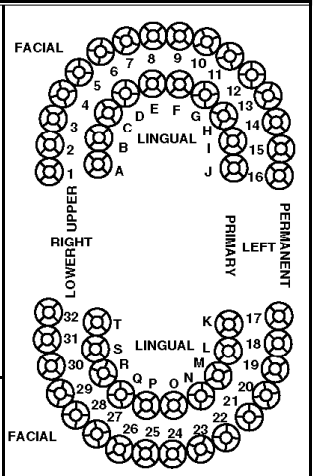
8. I hereby authorize release of any information relative to this claim to the insurer and direct that benefits be made payable to: ☐ Myself ☐ Dentist

Date Employee or Spouse Signature

PART II–TO BE COMPLETED BY ATTENDING DENTIST

	No	Yes	If YES, enter brief description and dates	
9. Is treatment result of occupational illness or injury?				
10. Is treatment result of auto accident?				
11. Other accident?				
12. Are any services covered by another plan or Medicare B?				
13. If prosthesis, is this initial placement?			If NO, Reason for Replacement	14. Date of Prior Placement

16. REMARKS FOR UNUSUAL SERVICES



Ir. Indicate Missing Teeth With An "X"

15. Is treatment for orthodontics? ☐Yes ☐No

If Yes,
Date of initial workup _____
Date of banding _____
Mos. Treatment Remaining _____

X-rays submitted

17. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32.

A Tooth No. or Letter	B Surface	C Date of Service	D Place of Service*	E Procedure Code	E Modifiers	Description of Services (Including X-rays, prophylaxis, materials used, etc.)	F Diagnosis Code	G Charges	H (For Administrative Use Only) Type Services	Days Units	MP SPI	AC Code	Disp	RB LF

18. Signature of Dentist
(I certify that the statements on the reverse apply to this bill and are made a part hereof.)
Signed Date

23. Accept Assignment *(See back)*

20. Total Charge

21. Amount Paid

22. Balance Due

24. Your Social Security No.

26. Dentist Name, Address, Zip code and Telephone No.
ID No.

19. Your Patient's Account No.

25. Your Employer ID No.

***PLACE OF SERVICE CODES**

1–Inpatient Hospital	3–Doctor's Office	5–Day Care Facility	7–Nursing Home	9–Ambulance	A–Independent Laboratory
2–Outpatient Hospital	4–Patient's Home	6–Night Care Facility	8–Skilled Nursing Facility	0–Other Locations	B–Other Medical/Surgical Facility